the handle of the small dagger he wore by his side."

Harvey rose rapidly in his profession and soon had important and fairly lucrative practice. In 1618 he was appointed physician extraordinary to James I. Harvey became one of the most eminent men of his time. In 1613 he was elected a censor at the College of Physicians, was re-elected in 1625, and again in 1629. He was one of the four censors who supervised those engaged in the practice of medicine in London and took action against quacks. The censors also visited the druggist and tested the drugs to see if they were genuine and up to standard. In 1627 he was made one of the "Elect," a body of eight men who chose one of their number as president, and who examined candidates for medical license.

CLINICAL NOTES, CASE REPORTS AND NEW INSTRUMENTS

TAMPON TREATMENT OF SINUS DISEASE IN CHILDREN

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A REVIEW of the literature on this important subject shows that there is very little written about it, and also that there is no mention of the tampon treatment in children with sinus trouble. We have had such uniformly good results in our few cases that we feel justified in presenting an outline of our procedures.

EMBRYOLOGY

According to Skillern the maxillary sinuses are present at birth, but are situated very high up and are internal and not just below the orbit. The floor of the antrum just about reaches the attachment of the inferior turbinate. This is important in operating on the antrum of a child, as in the adult the floor is usually about the level of the floor of the nose or lower. The frontal sinus appears between the first and third years as an upward expansion from the anterior ethmoidal cells, but it is not until the seventh to ninth years that the sinus may be recognized as a separate cavity. The frontal sinus is frequently absent on one or both sides. The ethmoidal cells are present at birth, and the sphenoid appears as but a faint depression in the body of the sphenoid bone. Reabsorption of the sphenoid bone commences at the second year, and by the sixth year the sinus is fairly well developed.

DIAGNOSIS

1. *History.*—The commonest complaints given are excessive nasal discharge, cough, frequent colds, undernourishment with failure to gain weight, "growing pains," headaches, impaired hearing, blinking of eyes, and bad breath. Patients are sometimes referred for examination for cause of bronchitis, asthma, or fever of unknown origin. Most of our cases have already had an adenotonsillectomy performed, but this of course is not always the case. Taking up a few of these symptoms more in detail, we find that the cough is usually of a hacking character and often is present just at night, since during the day it takes the form of "clearing the throat." The growing pains may be explained as a neuritis, myositis or arthritis from the focus in the sinuses; the headaches are usually vague, not well localized and usually are not severe; the impaired hearing is usually noted by the mother or schoolteacher, and at times seems to be intermittent. This intermittency is likely best explained by the fact that the patient has acute flare-ups with congestion of the eustachian tubes and tubotympanic catarrh. Another very interesting symptom we had in one case was continual blinking of the eyes which the mother thought was habit. After six tampon treatments the blinking disappeared. After several months the symptom returned, to be again controlled by a series of tampon treatments.

2. *Examination of Patient.*—On examination pus or mucoid discharge is usually found in one or both nares. We have been unable to see the ostia of sinuses in children or note any special pathology in the mucous membrane around the ostia, as has been described by some observers. We sometimes find infected tonsils or occasionally a cryptic tonsillar remnant with a large adenoid in the nasopharynx. One of the best signs we have noted is the lateral pharyngitis or streaks of hypertrophied lymphatic tissue down the nasopharynx or oropharynx, caused by the dropping down of irritating discharge from the sinuses. Another sign that is found in practically all cases is the enlargement of the postcervical glands. These glands are small and hard and are usually found in strings down both sides of the neck, often extending down over the scapula.

3. *X-Ray Findings.*—We do not find transillumination of any value in children, but do rely very much upon x-rays. The commonest pathological x-ray picture is cloudiness of the antra, although not uncommonly the ethmoids are also cloudy. X-ray pictures of the chest often show hilus scarring and peribronchial thickening. These cases are frequently diagnosed as pulmonary tuberculosis, when as a matter of fact clearing up the upper respiratory tract will often clear up the chest condition and all of the symptoms. Pictures taken before and after treatment will show that it is possible to clear up the pathology in the sinuses.

TREATMENT

The treatment will depend somewhat upon the findings. If infected tonsils and hypertrophied adenoids are present, they are removed first of all; this alone may clear up the condition. If this does not clear it up the patient is treated with nasal tampons, consisting of small strips of cotton saturated with 5 per cent neosilvol to which 1 per cent ephedrin in normal saline is sometimes added. The nose is packed as nearly full as possible, leaving the tampons in about ten minutes and treating the patient every other day for about six times. After putting in the tampons it is a good idea to tip the patient's head far back and add several drops of the mixture to each nostril, with the head first to one side and then to the other, so that it may run along the meati on both sides.

The theory of this treatment is mainly that of shrinkage of the mucous membrane, thus allowing the sinuses to drain more freely. The antiseptic value of the neosilvol is of less importance. It is difficult in some cases to get coöperation from such young patients, but if care is taken not to hurt them the first time they usually submit with ease to subsequent treatments. Between treatments drops of neosilvol and ephedrin are prescribed, to be used two or three times daily. Ephedrin should not be used too freely, as we have had several cases which have developed an idiosyncrasy to it.

If this does not clear up the symptoms an x-ray of the sinuses is taken. If the antra are cloudy the patient is given an anesthetic and the antra washed, using a 2.5-inch needle inserted under the inferior turbinate, always drawing back with a Luer first to make sure the needle is in the antrum. The antrum is filled with normal saline and aspirated, the fluid which returns into the Luer being examined. If it contains pus, mucous shreds or flakes, a window is made under the inferior turbinate as follows: first push up the inferior turbinate, next enter the antrum with a punch; withdraw the punch and insert an antrum rasp and rasp out the thick anterior angle. Next take a heavy punch forceps and punch out as far back as possible, making a large opening. No drain or pack is used. In some cases it is possible to wash the antra with a blunt trocar several days later, but this is often impossible unless one wants to give the patient a little gas. Following this the patient is given a series of tampon treatments and the condition usually clears up.

If the symptoms do not clear up following the above treatment it may be necessary to send the patient to a warm, dry climate, such as Needles, California, or the Santa Clara Valley. Sun baths are often very effective, starting out with an exposure of a few minutes and working up to about an hour a day. This acts as a very good tonic and increases resistance to infection. Treatments with a quartz lamp act in a similar way. Whenever it is possible a pediatrician should handle the medical care, the most important part of this being the diet. We find that a diet containing high vitamin content with food such as eggs, orange juice, carrots, and leafy vegetables is an aid to recovery. Cod-liver oil in some form is also very effective. It is not necessary in all cases to carry out all the treatment mentioned above before getting good results, but in some cases even the most radical procedure will not give complete relief of symptoms.

We are not presenting any case histories, but have mentioned the commonest and most interesting symptoms which have presented themselves, and as a whole these symptoms have cleared up under the above treatment. We have had only about fifty cases, and hence consider this only a preliminary report, hoping that we may be able to produce a more extensive and thorough article at a later date.

SUMMARY

1. *Symptoms.*—Nasal discharge; cough; frequent colds; undernourishment; "growing pains"; headaches; impaired hearing; blinking of eyes; bad breath; symptoms of asthma and bronchitis; fever of unknown origin.

2. *Examination of Patient.*—Pus in nose; infected tonsils or of tonsillar remnant; hypertrophied adenoid; lateral pharyngitis; postcervical adenopathy.

3. *X-ray findings.*

4. *Treatment.*—Adenotonsillectomy or removal of adenoid and tonsil remnant; nasal tampons with drops in nose; washing of antra and opening if necessary; dry, warm climate; sun baths or quartz lamp treatment; diet and cod-liver oil.

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EROSIO INTERDIGITALIS BLASTOMYCETICA*

CASE REPORT

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IN May, 1917, Fabry [1] reported a series of yeast infections of the hands to which he gave the name erosio interdigitalis blastomycetica. In 1918 Berendsen [2] published a paper on the same subject. In 1918 Fabry [3] published another paper. In April, 1921, Stickel [4] reported a series of forty-five cases, thirty-eight of which occurred in women. In March, 1922, Greenbaum and Klauder [5] published a thorough paper on yeast infections of the skin. Mitchell [6] in December, 1922, published a series of three cases.

Erosio interdigitalis or saccharomycetica are offered as substitutes for the term erosio interdigitalis blastomycetica, which is confusing. The causative organism is not the blastomycetes.

I do not think that race has anything to do with this condition except as far as the use of soap and water is concerned, although eleven of twelve cases occurred in Jewish women. I have never encountered this condition in orthodox Jewish women who use washing powders.

My series consists of twelve cases: two of these patients failed to report for observation subsequent to the final scrapings, which were negative for yeast organisms.

CASE REPORT

Mrs. B., age fifty-four, occupation dishwasher, presented a lesion limited to the web of the third interspace of the right hand. The lesion first appeared about eight months ago and remained constantly in the same area, and showed no tendency to spread to the palmar or dorsal surfaces. Itching and burning was intensified by having the hands in soapy water. During a vacation of two weeks a slight remission occurred.

Examination.—The web of the third interspace showed a sharply defined, shiny, red epidermis surrounded by a collarette of upturned scales. Vesicle formation and fissures were absent. Scattered over the red epidermis were small areas of thin, white macerated epidermis which could be removed only with a great deal of difficulty and discomfort to the patient.

Thorough examination of the feet showed no mycotic infection.

Microscopic.—Small pieces of thin, white, macerated epidermis soaked in 40 per cent KOH. disclosed numerous double contoured spores which were budding, and solid mycelial threads. Tissue planted in

* Read before the Dermatology and Syphilology Section, California Medical Association, at its Fifty-Seventh Annual Session, April 30 to May 3, 1928.